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RESPONSE: TOWARD BETTER LIVES

Danny Hall, Ph.D., Dave Ross, Ph.D., and Lucy Zammarelli, M.A., N.C.A.C. II, C.A.D.C. III

Lucy Zammarelli: I like the way the article pulls substance abuse treatment into a standardized medical perspective. Quality of life is typically a goal in treating many diseases other than substance abuse. In the drug abuse field, it provides a broader, more encompassing gauge of success than just whether the client used a drug or how much.

Dave Ross: The issue is extremely important. Quality of life doesn't mean just that somebody is now sober. It's much more than that, and it takes a multidimensional program with some longevity to truly address it.

Zammarelli: The quality-of-life concept gives us a way to talk to patients about their situation that doesn't play into the shame that surrounds this disease. Instead of pathologizing their behavior, we can say, "Our goal is to help you succeed in your life."

Danny Hall: I practice patient-centered care. My perspective is that if you're truly doing patient-centered care, your outcome is quality of life. And if you're doing a good job, quality of life will improve.

Instruments and relationships

Zammarelli: I would like to become more familiar with the WHOQOL form that's mentioned in the article. We don't use anything like that in our program.

Hall: In our program at the VA, we don't objectively measure quality of life. We use an assessment called the Brief Addiction Measure, which covers quality-of-life issues very broadly with questions about mental and physical health; cravings; work, school and volunteer activities; and religion and spirituality. I think that ultimately it will be a very useful instrument, but so far we don't have norms on it.

Ross: At Catholic Charities, we give patients a form that has check-off boxes for mental and addiction issues, general and sexual health, chronic medical problems, food, clothing, shelter, and so on. Patients fill it out at intake and again when they exit the program to measure their progress. Most importantly, we use it as a clinical tool.

Interestingly, we initially designed the form using seven-point Likert scales, but that turned out to be too complex for some folks at intake. We shortened the form to three-point scales, and that has been much more successful.

Zammarelli: Our field has much to gain from adopting standardized instruments like the WHOQOL. We have such eclectic working methods; it'll be good for everyone when we can develop a standardized vocabulary. Quantifiable empirical data on quality of life will also be very useful.

Hall: Right. Our program just had a visit

from a tracer for the Joint Committee on the Accreditation of Healthcare Organizations (JCAHO). She told us that we're going to have to show JCAHO that we are using data to guide our decisions about changes to the program. They won't be satisfied with us just telling them why we thought something was a good idea. We're going to have to show them the data that we generated to help us choose between option A and option B.

Zammarelli: A broadly used instrument like the WHOQOL can also relieve stigma. We can say to patients, "We're going to give you a screener that's like one that's used in heart disease and diabetes to help us determine our goals in treatment."

Ross: In my experience, much of the quality-of-life material that researchers develop tends to be top-down. The instruments assess what researchers think counts toward quality of life. So there will be items on food, clothing, shelter, abstinence, and so on. At Catholic Charities, we think it's also important to ask clients about quality of life in their own frame of reference. For example, have they reconnected with their friends, taken up a hobby or a sport or something else that they used to do?

Zammarelli: Relationships are a key aspect of quality of life. Many, many clients have had a terrible lack of caring, loving relationships in their lives. Their empathic

relationships with their counselors are the main factor in their continuing in treatment. The caring social connections that they form with others who are battling the same disease often are also critical.

Ross: I think some patients, particularly homeless people who enter treatment reluctantly, grieve over the people they knew on the street. They've become very attached to those people—who looked after them, protected them, and probably stole money and drugs from them, too. The patients have lost their primary social group, and often there's no one else left who has much empathy for them. I mean, on the way to becoming a full-blown addict, you trash a lot of people. It's hard to go back and say, "Okay, I need your help now."

Treatment goals

Hall: I was concerned that the author defined recovery as "abstinence plus quality of life." Throughout the article, the assumption seems to be that all therapy should aim to produce abstinence. That way of thinking overlooks the field of harm reduction therapy. It doesn't speak to the fact that people can be in multiple stages of change for each substance they use.

Ross: I noticed that, too. Our program serves three counties, and one of them, San Francisco, requires us to use harm reduction models. However, I just assumed that harm reduction wasn't a focus of this particular article.

Hall: For example, someone may come in and say, "I've got an abstinence goal for alcohol, a harm reduction goal for cocaine, and I don't want you to touch my cigarettes." If we are practicing patient-centered medicine, we have to accept that and work with it. Of course, somewhere during the course of therapy, we're going to show the patient

that his use of all these drugs is related. The lighter that lights cigarettes also lights other things, and cigarettes are a trigger for cocaine use.

Zammarelli: We would not call ours a harm reduction program. I think that in general, people who are spending money on treatment expect abstinence to be a primary outcome. Insurance companies and drug courts certainly do.

A main reason that abstinence is a gold standard is that many people are aware that they can maintain recovery if they maintain abstinence. They know that if they chip away at a substance, have a few tokes or a couple of drinks, they can slide back down into the progressive nature of the disease.

At the same time, addiction is an episodic condition, and people go in and out of using. For that reason, broadening the idea of treatment and patient success is good, and it fits with the harm reduction model.

Ross: I like that clarification.

Hall: Yes. The "abstinence *eventually*" mindset makes a lot of sense to me.

Zammarelli: There is a question as to how much we can improve a patient's quality of life in the course of a treatment episode. With a mandated patient who has a co-occurring disorder, achieving initial stabilization and at least attempting abstinence can easily take 45 days. Then beginning to comprehend the quality-of-life issue and getting on track to deal with it can take up another 45 days. Now we are at the end of our 90-day treatment, and we've just started to help someone look at real quality-of-life issues like education and caring relationships.

Hall: I don't want to be Pollyanna-ish about it and say there's no limit to what we can

achieve. However, I think putting limitations on goals for patients is problematic. Some research has shown that therapists' negative perceptions about patients' prospects for recovery can become self-fulfilling prophecies.

I let patients decide how we'll improve their quality of life. I often say, "You are the captain of your own boat. I have a couple of maps. So what do you want to do about your quality of life?"

Ross: To follow up on that idea, I encourage my clinicians to ask patients if they're feeling better. Sometimes the answers are surprising. The clinician might assess the person objectively and think he or she is still angry in group therapy, or see some other sign that progress isn't being made, but the patient might say, "Things are terrific compared with where I was."

This goes back to the patient's frame of reference. Once a patient came to me and said, "Dr. Ross, I really made it." I said, "What happened?" He had a new housing situation. He had moved from sleeping in an alley into an abandoned car. So he had created a home, with a roof that kept him dry, and for him that was a terrific advance in quality of life.

Zammarelli: Substance abusers sometimes have a frame of reference that makes them think they need to achieve magnificent goals before they can feel good about themselves. Their drug use leaves them with a weird mix of disempowerment and narcissism, shame, and feelings that they are unique and amazing. We try to help our patients see that it's all right to just be a person who has a house to live in and a job to work at and meaningful relationships. The quality-of-life perspective helps with this. It says, "It's enough to be average; you don't have to be so special or win any awards."